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No. 05-260

IN THE

Supreme Court of the United States

JOEL SEREBOFF AND MARLENE SEREBOFF,
Petitioners,

v.

MID ATLANTIC MEDICAL SERVICES, INC.,
Respondent.

On Writ Of Certiorari to the United States Courts of Appeals for the Fourth Circuit

AMICUS CURIAE BRIEF OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA IN SUPPORT OF PETITIONERS

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AMICUS CURIAE BRIEF OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA IN SUPPORT OF PETITIONERS

IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Association of Trial Lawyers of America ["ATLA"] respectfully submits this brief as *amicus curiae*. The parties have filed blanket letters of consent to the filing of amicus briefs with this Court.[1]

ATLA is a voluntary national bar association whose approximately 50,000 trial lawyer members primarily represent individual plaintiffs in personal injury cases and other civil actions.

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[1] Pursuant to Rule 37.6, Amicus discloses that no counsel for a party authored any part of this brief, nor did any person or entity other than Amicus Curiae, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

ATLA is concerned that the decision below, and other federal decisions permitting ERISA plans to enforce reimbursement provisions, will have a devastating and unfair impact on many American workers. At a time when an employee is seriously injured, he or she will be subjected to lawsuits by their own health plan for repayment of benefits out of tort recoveries intended to compensate for lost income, future medical expenses, and other losses. Many plans also refuse to pay a fair share of the legal expenses incurred to obtain the tort recovery.

Congress did not authorize reimbursement lawsuits under ERISA, and this Court should resist calls to broadly interpret the statute to allow such harsh enforcement actions.

SUMMARY OF THE ARGUMENT

1. The lower court erred in holding that MAMSI's lawsuit was permissible under §502(a)(3) of ERISA as "other equitable relief." This Court has made clear that §502(a)(3) authorizes only those actions by plan fiduciaries that were typically available in courts of equity. It does not permit actions that essentially seek money damages for breach of contract.

The sole basis for MAMSI's claim is its contract provision calling for reimbursement out of recoveries from third parties. MAMSI's suit fits squarely within the recognized cause of action for legal, rather than equitable, restitution.

The court below erroneously concluded that MAMSI made out an equitable cause of action for return of funds within the Sereboffs' possession. Those funds, however, were never MAMSI's. The proper focus is the amount paid out by MAMSI to the Sereboffs' medical providers. Those funds have been

dissipated, and MAMSI has only a legal cause of action for repayment.

There is no sound reason for this Court to depart from its strict construction of §502(a)(3). Congress omitted such authorization from its carefully crafted and detailed enforcement scheme. Moreover, Congress enacted ERISA to protect employees from abuses and hardships inflicted by those responsible for their benefit plans. In addition, Congress acted against the background of the common law prohibition against subrogation to recover medical benefits. The Court should defer to Congress's responsibility to balance competing interests and determine whether reimbursement lawsuits serve the public good.

2. Reimbursement lawsuits do not serve the public policies claimed by proponents. They do not target "double recoveries" by plan beneficiaries. Most tort plaintiffs, particularly the seriously injured, do not receive full compensation in the tort system. The limits of liability insurance, legal expenses, and other factors result in less than full compensation. Tort reform statutes also result in undercompensation, often for the purpose of shifting part of that burden to first-party insurance, including ERISA plans.

Nor does reimbursement serve to reduce the costs of coverage for participants in ERISA plans. Commercial insurers do not take anticipated reimbursements into account in setting premiums. Though self-funded plans may realize some savings, the reduction in cost for coverage to the typical employee would be miniscule.

More fundamentally, the proposal to impose economic hardship on a few beneficiaries so that the

many might save a small sum is inconsistent with the purpose of ERISA. It is insurance running in reverse.

3. If this Court does determine that ERISA authorizes reimbursement lawsuits, such "equitable relief" should be truly equitable. The Court should follow the lead of the great majority of state courts and hold that, as a matter of federal common law, a plan has no right of subrogation or reimbursement out of a tort recovery until the beneficiary has been made whole. In addition, the Court should make clear that, to prevent unjust enrichment, an ERISA plan reimbursed from a tort recovery must bear a proportionate share of the costs and attorney fees expended to obtain the tort recovery.

ARGUMENT

I. A SUIT BY AN ERISA PLAN TO ENFORCE A PLAN PROVISION TO REIMBURSE THE PLAN OUT OF THE PROCEEDS OF A TORT RECOVERY IS AN ACTION AT LAW, UNAVAILABLE UNDER ERISA.

A. Reimbursement Lawsuits Are Actions for Legal, Not Equitable, Reimbursement.

Following their automobile accident, Joel and Marlene Sereboff, find themselves at the center of a controversy that will determine whether thousands of American workers will receive the medical benefits and security promised by their employer-sponsored health plans. The Sereboffs are

beneficiaries of an ERISA[2] medical benefits plan provided by Mrs. Sereboff's employer and administered by Mid Atlantic Medical Services, Inc. [MAMSI] as fiduciary. After the Sereboffs settled their personal injury action against several alleged tortfeasors, MAMSI brought suit for reimbursement of $74,869.37, paid under the plan for their medical expenses. MAMSI's sole basis for its claim to this amount is a provision in its Plan:

> If you or your dependent receives benefits and have a right to recover damages from a third party, the Company is subrogated to this right. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Company net of reasonable attorney fees and court costs . . .

MAMSI Plan at 29.

The district court granted summary judgment to the plan, and the Fourth Circuit affirmed, holding that "MAMSI's action seeks equitable restitution, as that term is used in *Knudson*, because MAMSI seeks to recover funds that are specifically identifiable, belong in good conscience to MAMSI, and are within the possession and control of the Sereboffs." 407 F.3d at 218.

This Court in *Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204 (2002), emphasized that the civil enforcement actions enumerated by Congress in §502(a)(3) of ERISA are the only actions a plan fiduciary may bring to enforce provisions of the plan. Moreover, the "equitable relief" authorized

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[2] The Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 891, 29 U.S.C. §1001-1461 (2003).

by that section is limited to those actions "typically available at equity." *Id.* at 211. The Court further held that such actions do not include those that are essentially breach of contract actions. *Id.* at 213.

In *Knudson*, the plan could not state a claim for equitable reimbursement because the beneficiaries were not in possession of the funds the plan sought. That the funds in this case are in the Sereboffs' possession does not call for a different outcome. Possession is a necessary, but not sufficient requirement for equitable restitution. MAMSI's action in this case, and indeed reimbursement actions by ERISA plans generally, cannot qualify as "other equitable relief' authorized by ERISA.

1. MAMSI's Claim For Reimbursement of Medical Benefits Is A Cause Of Action Historically Recognized As Legal Restitution.

This Court in *Knudson* characterized lawsuits like MAMSI's as actions for restitution. Justice Scalia, writing for the Court, explained that, in the days of a divided bench, some restitutionary actions were legal, while others were directed to courts sitting in equity. *Id.* at 212-15, citing 1 Dan B. Dobbs, LAW OF REMEDIES §§ 4.2(1) & 4.3(1) (2d ed.1993). He added, "whether [restitution] is legal or equitable depends on 'the basis for [the plaintiff's] claim' and the nature of the underlying remedies sought." 534 U.S. at 213.

As the Fourth Circuit acknowledged, the sole basis for MAMSI's claim that "the disputed funds belong in good conscience to MAMSI" is the Plan's "express, unambiguous reimbursement provisions." 407 F.3d at 218-19. Thus, MAMSI's claim is essentially based on breach of its contract by the

Sereboffs, notwithstanding the plan's attempts to "dance around the word." *Mertens v. Hewitt Associates*, 508 U.S. 248, 255 (1993).

Secondly, "the nature of the underlying remedies sought" places this case squarely on the law side. *Knudson* at 213. As Professor Dobbs explains, restitution at law deals with cases where the plaintiff is entitled to return of his property because (1) he has legal title or (2) he is "able to show just grounds for recovering money [used] to pay for some benefit the defendant had received." Dobbs, §4.2(1) at 571; *see also Knudson*, at 213. MAMSI's cause of action clearly falls within the second category of legal relief.

One of the recognized counts of restitution at law was known as "money had and received." As described by Professor Dobbs,

> When the defendant himself received money that belonged in good conscience to the plaintiff . . . the plaintiff was entitled to restitution of the money, which is said to have been received by the defendant for the use of the plaintiff. The count includes *money paid by a third person* so long as the money in good conscience belongs to the plaintiff.

Dobbs, at §4.2 (emphasis added).

An example is found in *Gaines v. Miller*, 111 U.S. 395 (1884). An estate's agent received money from a third party in exchange for estate property. Despite the agent's obligation under implied contract to pay the funds over to the estate, the agent kept some of the money. Years later Gaines, the legatee of the estate, sued Miller, the administrator of the deceased agent's estate, seeking an equitable

reimbursement. The Court held that the equity court had no jurisdiction over the action.

> It is, therefore, simply a case of money had and received by him for the use of appellant, . . . Whenever one person has in his hands money equitably belonging to another, that other person may recover it by assumpsit for money had and received. The remedy at law is adequate and complete.

Id. at 397-98 (citations omitted).

Equitable restitution, by contrast, seeks to divest the defendant of property wrongfully gained. The relief "is measured by the defendant's unjust enrichment, not by the plaintiff's loss." Dobbs, at §4.5(1). In this case, MAMSI seeks repayment of the amount paid by the plan for the Sereboffs' medical treatment, which were not wrongfully obtained nor an unjust enrichment of the Sereboffs. MAMSI's suit is clearly an action at law, and is not authorized by ERISA §502(a)(3).

2. MAMSI's Action Does Not Meet the Requirements of Equitable Restitution.

Justice Scalia in *Knudson*, indicated that "for restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to *restore to the plaintiff particular funds or property* in the defendant's possession." *Id.* at 213-14 (emphasis added).

The court below erroneously concluded that MAMSI's cause of action met these requirements because it "seeks to recover funds that are specifically identifiable, belong in good conscience to MAMSI, and are within the possession and control of the Sereboffs." 407 F.3d at 218.

The court's error lies in focusing on the tort settlement as the "particular funds or property" to be restored to the plaintiff. MAMSI never owned those funds. Its only claim on them is its plan provision identifying third-party recoveries as the source out of which beneficiaries must repay medical benefits. To hold that this provision makes MAMSI "in the eyes of equity, the true owner" of the settlement, *Knudson* at 213, would enable every breach of contract to pay money to be transformed into an equitable action. Such an interpretation would render Congress's restrictive language in §502(a)(3) meaningless and essentially repeal "the unmistakable limitation of the statute." *Knudson* at 217. *Cf.*, 51 Am. Jur. 2d Liens §29 (1970) (An equitable lien requires "more than a mere expectation, or even an agreement, that a debt will be paid out of a particular fund.").

The proper focus of inquiry should be the $74,869 paid out by MAMSI under the plan. If a constructive trust is to be imposed on money, it must be an identifiable fund traceable to the plaintiff. 1 Dobbs, §4.3(2), at 590. The "idea is that the plaintiff's property has been found in the hands of the defendant and must be restored to the plaintiff, . . . even if the property has undergone a change in form." 2 Dobbs, §6.1(2), at 7-8. *See also United States v. Benitez,* 779 F.2d 135, 140 (2d Cir. 1985) ("It is hornbook law that before a constructive trust may be imposed, a claimant to a wrongdoer's property must trace his own property into a product in the hands of the wrongdoer.").

> In a reimbursement action, however, the only money traceable to the plaintiff is that which has already been dissipated to pay for the policyholder's medical expenses. The third-party recovery, upon which the insurer seeks the trust

> or lien, is not traceable to the insurer; the insurer's only claimed right to that fund is the contract right embodied in the ERISA plan, and this relief is absolutely foreclosed after *Knudson*.

David D. Leishman, *Adding Insult To Injury: ERISA, Knudson, and the Error of the Possession Theory*, 89 Minn. L. Rev. 1214, 1233-34 (2005).

In this case, MAMSI's $74,869 was never in the possession of the Sereboffs; it was paid to medical providers and dissipated. The settlement funds are completely separate property, traceable only to the third-party tortfeasor or its insurer. It was rightfully paid to the Sereboffs as compensation for tortiously inflicted harms, and would have been paid regardless of whether past medical expenses had been paid by MAMSI or by the Sereboffs themselves.

B. This Court Should Not Interpret ERISA To Authorize Plans to Sue Beneficiaries For Reimbursement of Covered Medical Expenses Out of Tort Recoveries.

Amicus anticipates that Respondent and supporting amici will urge this Court to depart from its prior construction of §502(a)(3) and expansively interpret that section to allow reimbursement actions. Amicus urges the Court to reaffirm its position in *Knudson*, hewing close to the statutory text and deferring to Congress's responsibility to determine whether allowing lawsuits by fiduciaries against beneficiaries strikes the appropriate balance among competing interests and serves the public good.

ERISA's text and history strongly indicates that Congress did not intend to grant fiduciaries this authority.

First, Congress in providing civil enforcement remedies for plan fiduciaries under ERISA, made no provision for subrogation or reimbursement, as it has in other statutes.[3] In fact, in §502(a)(1)(B), Congress authorized actions to enforce provisions of benefit plans, but strictly limited such actions to beneficiaries and participants, excluding plan fiduciaries.

This Court has justifiably refused to interpret ERISA's civil enforcement provisions broadly. The Court has recognized that ERISA's "carefully crafted and detailed enforcement scheme provides 'strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.'" *Knudson*, at 209, quoting *Mertens, supra*, at 254. For this reason, the Court has stated its "unwillingness to infer causes of action in the ERISA context." *Mertens*, at 254 (1993).

Secondly, Congress enacted ERISA to protect workers who had been deprived of expected benefits by those responsible for their benefit plans. The saga of ERISA began in 1963, when financially troubled automaker Studebaker defaulted on its pension plan, frustrating the expectations of thousands of workers and retirees. *See* James A. Wooten, *"The Most Glorious Story of Failure in the Business": The*

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[3] See, e.g., 42 U.S.C. §2651-2653 (authorizing the Veterans Administration under the Medical Care Recovery Act to recover benefits from beneficiaries who have obtained tort recoveries); 42 U.S.C. § 1395y (providing for reimbursement to the Social Security Administration).

Studebaker-Packard Corporation and the Origins of ERISA, 49 Buff. L. Rev. 683 (2001). Other scandals followed in which workers found that the benefits they had counted on were not there. *See generally*, Michael S. Gordon, Overview: Why Was ERISA Enacted?, in U.S. Senate Special Comm. on Aging, 98th Cong., The Employee Retirement Income Security Act of 1974: The First Decade 6-24 (Comm. Print 1984).

Following "a decade of congressional study of the Nation's private employee benefit system," *Knudson* at 209, Congress enacted ERISA to address "the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardship to so many." H.R. Rep. No. 93-533, at 9 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4647.

In view of this history, it is unlikely that Congress intended the phrase "other equitable relief" to hand fiduciaries a blank check, allowing them to write their own law by authorizing enforcement of any provisions they choose to incorporate into a plan's provisions.

Thirdly, Congress enacted ERISA against the background of a long common law history that prohibited subrogation actions by an insurer to recover medical expenses. Although such actions were permissible in property damage cases, subrogation rights to covered medical expenses caused by a tortfeasor "had been disallowed by virtually all courts until recently." Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D.L. Rev. 237, 239-40 (1996).

During the 1960s, insurers found they could avoid that prohibition by rewriting subrogation clauses to call for "reimbursement." Roger M. Baron, *Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 Mercer L. Rev. 595, 603 (2004). During the period that Congress was working on ERISA, "it is doubtful that the matter of reimbursement was even in existence as an insurance lexicon. Certainly, the idea of reimbursement had yet to be presented or approved by the courts." *Id.* at 617-18. In one of the first reported decisions to address reimbursement provisions, one state court judge decried the "creeping erosion of the anti-subrogation principle." *Lee v. State Farm Mutual Automobile Ins. Co.*, 129 Cal. Rptr. 271, 278 (Ct. App. 1976) (Freidman, J., concurring).

The controversy has not abated.

> Some jurisdictions have never permitted subrogation or reimbursement for medical expense claims. Even today, some jurisdictions, which initially decided to permit subrogation on medical expense claims, have since reconsidered the appropriateness of doing so. These jurisdictions have come to conclude, either by judicial decision or by statute, that subrogation and reimbursement on medical expense claims is inappropriate and should not be allowed.

Baron, 55 Mercer L. Rev. at 603. *See, e.g.*, *Pennsylvania Gen. Ins. Co. v. Austin Powder Co.*, 502 N.E.2d 982, 983 (N.Y. 1986) ("An insurer has no right of subrogation against its own insured for a claim arising from the very risk for which the insured was covered."); *see also Allstate Ins. Co. v. Reitler*, 628 P.2d 667, 670 (Mont. 1981), and *Maxwell*

v. Allstate Ins. Cos., 728 P.2d 812, 815 (Nev. 1986), both holding plan provisions requiring reimbursement of medical payments void as a matter of public policy). Several states have acted legislatively, adopting anti subrogation statutes. *See, e.g.*, Okla. Stat. Ann. tit. 36, §6092 (West 2001); 75 Pa. Cons. Stat. Ann. §1720 (West 2001).

Among those states that permit subrogation or reimbursement, the great majority allow reimbursement only after the injured insured or beneficiary has been made whole. *See* Part III, *infra*.

It is unlikely Congress would have intended to authorize fiduciaries to institute actions that were historically prohibited at common law and which are so antithetical to public policy that the overwhelming majority of states either ban such actions or permit them only after the insured has been made whole. Certainly Congress would not have taken such a drastic step without discussion or by using the opaque phrase "appropriate equitable relief."

Finally, it is the responsibility of Congress to determine whether reimbursement suits are in the public interest and, if so, to amend the statute. Indeed, legislation passed by the House on Dec. 15, 2005, would amend §502(a)(3) to authorize "an action by a fiduciary . . . enforcing terms of the plan that provide a right of recovery by reimbursement or subrogation." Pension Protection Act of 2005, H.R. 2830, 109th Cong., §307 (2005).

Amicus suggests that in this area, it is most appropriate for the Court to resist calls for a distorted and expansive interpretation of the statutory text and allow Congress to carry out its responsibility to "resolve[] innumerable disputes

between powerful competing interests – not all in favor of potential plaintiffs." *Knudson*, at 209.

II. UNRESTRICTED REIMBURSEMENT OF ERISA PLANS OUT OF THE BENEFICIARY'S TORT RECOVERY DOES NOT SERVE PUBLIC POLICY AND UNDERMINES THE PURPOSES OF ERISA.

Insurance companies and health plans justify reimbursement as eliminating a "double recovery," merely depriving the beneficiary of a "windfall." *See e.g.*, Brief of Amici Curiae the American Associations of Health Plans, et al. at 16, Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002) (No. 99-1786). Additionally, reimbursement is often portrayed as "cost-containment," without which the cost for all beneficiaries must necessarily increase. *Id. See also* Brief of Amicus Curiae Self-Insurance Institute of America, Inc., at 6-9, *Knudson* (No. 99-1786). Neither argument has any factual basis.

A. Reimbursement Does Not Prevent "Double-Recovery." But Deprives Beneficiaries of Legal Redress and Compensation for Their Injuries.

At the outset, Amicus submits that the term "double recovery" in this context is particularly inapt. It indicates the beneficiary was entitled to only one recovery, but obtained two. Even where an individual's tort recovery fully compensates for his or her losses, "[p]recluding the subrogation of the insurer does not result in a double recovery for the insured because the insured is merely receiving the benefits for which he has already paid. Allowing subrogation . . . results in a windfall recovery for the

insurer." *Maxwell v. Allstate Ins. Cos.*, 728 P.2d 812, 815 (Nev. 1986); *see also, Allstate Ins. Co. v. Reitler*, 628 P.2d 667, 670 (Mont. 1981) (similar); *Allstate Ins. Co. v. Druke*, 576 P.2d 489, 492 (Ariz. 1978) (similar).

In most cases, however, injured plaintiffs, especially those suffering serious injury, do *not* recover for all their losses from the tortfeasor. A verdict or settlement in a personal injury case represents the sum of the plaintiff's various proven compensable damages. These might include past medical expenses, future medical care, rehabilitative expenses, past lost income, lost earning capacity for the future, physical pain and suffering, and property damage. In the appropriate case, a claimant might also be entitled to the costs of job retraining, or modifying his or her home to accommodate a disability.

Yet, "scholarly research documents that more seriously injured victims tend to recover only a part of their total financial losses, notwithstanding the supposed legal entitlement to full compensation." Kenneth S. Abraham, Robert L. Rabin, Paul C. Weiler, *Enterprise Responsibility For Personal Injury: Further Reflections*, 30 San Diego L. Rev. 333, 340 (1993). The most seriously injured plaintiffs tend to be the most undercompensated. "In fact, the consistent undercompensation [of personal injury plaintiffs] at the higher end is so well replicated that it qualifies as one of the major empirical phenomena of tort litigation." Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System – And Why Not?* 140 U. Pa. L. Rev. 1147, 1218 (1992).

To permit an ERISA plan to take its reimbursement for medical expenses out of funds intended to compensate other losses does not divest the injured beneficiary of a double recovery. It deprives that person of the single legal redress to which he or she is entitled under state law.

The vast majority of tort actions end in settlement, and the settlement amount is very likely to be less than full compensation for the plaintiff's losses. Often the defendant's available liability insurance is insufficient. A plaintiff may also agree to settle for a lower recovery to avoid the delay and cost of pursuing the case to a verdict, as well as the uncertainty of prevailing at trial or on appeal. In addition, or rather subtraction, attorney fees and litigation expenses reduce aplaintiff's net recovery.

Consequently, even large tort awards for serious injury seldom represent a "windfall."

> The sad fact in the vast majority of these critical injury cases is that the insured is left not only seriously impaired for life, but, if reimbursement is permitted, the insured is also left financially destitute.

Baron, *supra,* 55 Mercer L. Rev. at 597.

Examples of the potentially devastating effects of reimbursement are legion, including some that are well known to this Court. In *Knudson*, Janette Knudson was rendered quadriplegic in a car crash. The ERISA plan paid $411,157 of her medical expenses. (Most of this expense was paid by Great West, a commercial insurer, insurance company pursuant to its "stop-loss" agreement with the plan). Her suit against several tortfeasors proceeded to settlement. After deducting attorney fees, costs, and repayment of Medicaid, the California court

allocated $256,745 to a Special Needs Trust to provide for Janette's continuing medical care; and designated $13,828 as compensation for past medical expenses. *Great-West Life & Annuity Ins. Co. v. Knudson*, 2000 WL 145374 (9th Cir. 2000) (unpublished) at *1. A check for that amount was sent to Great West. The company rejected the payment and sued Knudson to capture the entire amount in the Special Needs Trust as reimbursement. *Id.*

If this Court had not denied reimbursement, Janet Knudson would have been left with nothing to pay for her care for the rest of her life, despite both the legal redress she had obtained from the tortfeasor for this purpose and despite the payments accepted by the plan to provide her medical coverage.

Also familiar to this Court is the plight of the beneficiary in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). Fifteen-year-old Cynthia Holliday was severely and permanently injured in an automobile accident. Her medical expenses exceeded $178,000 and she faced future medical expenses. *FMC Corp. v. Holliday*, 885 F.2d 79, 80 (3d Cir. 1989). FMC's self-funded medical plan, in which Cynthia's father was an employee participant, paid a portion of her medical expenses. 498 U.S. at 54. Holliday and others injured in the accident brought a negligence action against the driver. The suit was settled for the driver's liability policy limits, and Holliday's share of the settlement was $49,825. The plan sued Cynthia for reimbursement, seeking the entire settlement amount, leaving her with nothing to pay for medical expenses that were not covered or the care she would need in the future. This Court held that Pennsylvania's anti-subrogation statute, which was

enacted to prevent this kind of harsh result, was preempted by ERISA. 498 U.S. at 65.

In the lower federal courts, ERISA plans have demanded reimbursement under provisions like MAMSI's, with little regard to the devastating impact on their own beneficiaries. An example is *In re Paris*, 44 F. Supp. 2d 747 (D. Md. 1999), aff'd, .211 F.3d 1265, 2000 WL 384036 (4th Cir. 2000) (unpublished). Shawn Paris, twenty-four years old, was severely injured and suffered permanent brain damage when his motorcycle was hit by a negligent driver. He was a participant in the Iron Workers' Trust Fund, whose ERISA plan covered medical treatment costing over $100,000. Paris' lawsuit against the driver was settled for $100,000. The plan, like MAMSI's, required that *any* amounts recovered from a third party be used to reimburse the plan. The district court held, and the Fourth Circuit affirmed, that the plan's subrogation provision must be enforced according to its terms. Consequently, the plan was entitled to the entire settlement.

The Fourth Circuit acknowledged "the possible hardships when an accident victim must reimburse a plan even when not made whole." 2000 WL 384036 at *3. Nevertheless, Shawn's mother and legal guardian was left with nothing to care for her brain damaged son for the remaining 51 years of his expected life. Adding insult to injury, the court rejected her request that the plan at least pay its share of the costs and attorney fees expended to create the settlement fund in the first place. *Id.*

These and many other examples make clear that the overriding issue does not concern "windfalls," which seldom occur. Rather, the question

is: Who shall bear the risk that a tort recovery will not be sufficient to make the plaintiff whole for his or her injuries?

Amicus submits that the medical benefits plan, which has accepted payment for coverage of the beneficiary's medical expenses and is in the business of spreading the costs of medical expenses, is the appropriate party to bear that risk. To permit the plan to grant itself first priority and take its repayment in full before the injured beneficiary's other losses are compensated cannot be deemed equitable and is not consistent with Congress's purpose of fostering coverage under employee benefit plans.

B. Reimbursement Imposes the Costs of State Tort Reform Laws On Innocent Victims, Undermining Both State and Federal Policy.

Another reason many plaintiffs recover less than full compensation for wrongful injury is found in tort reform legislation enacted in most states. These statutes vary greatly in their scope and effect. However, a common objective is to shield the tortfeasor from the obligation to fully compensate the injured plaintiff, in the hope of reducing the cost of liability insurance premiums. Supporters frequently state that full compensation of accident victims through the tort system is expensive and inefficient and would be better accomplished by first-party insurance, with its lower transaction costs. *See* Victor E. Schwartz, *Tort Law Reform: Strict Liability and the Collateral Source Rule Do Not Mix,* 39 Vand. L. Rev. 569, 574 (1986). *See also* George L. Priest, *The Current Insurance Crisis and Modern Tort Law,* 96 Yale L.J. 1521, 1550-63 (1987), a highly

influential work, arguing that a shift from first-party insurance to third party liability insurance was the root cause of the insurance crisis of the mid-1980s.

Most states, for example, have abolished or greatly restricted the collateral source rule. The common law rule required a tortfeasor to compensate a prevailing plaintiff for medical expenses resulting from wrongful injury, regardless of whether those expenses were covered by the plaintiff's health plan or insurer. Restatement (Second) of Torts § 920A(2) (1979). *See generally,* Richard C. Maxwell, *The Collateral Source Rule in the American Law of Damages,* 46 Minn. L. Rev. 669 (1962).

Most states have eliminated this rule to some extent.[4] Some statutes are applicable in all personal injury cases, while others affect specific tort actions. *E.g.,* Cal. Civ. Code § 3333.1 (medical malpractice). Some admit evidence of collateral source payments for the jury's consideration in determining damages. *E.g.,* Colo. Rev. Stat. § 13-21-111.6. Others require the court to deduct such amounts from the verdict before entering judgment. *E.g.,* 40 Pa. Cons. Stat. Ann. § 1303.508 (West Supp. 2004).

Many of these statutes were enacted in response to the recommendation by a federal inter-agency working group, which concluded that "elimination of subrogation (that is, simply offsetting all collateral sources against the award, and prohibiting subrogation arrangements) may have a limited effect and be justified on the basis of

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[4] The American Tort Reform Association, which tracks such legislation, reports that 36 states have restricted the collateral source rule. See http://www.atra.org/issues/index.php?issue=7344

significant reductions in transaction costs." U.S. Dep't of Justice, REPORT OF THE TORT POLICY WORKING GROUP ON THE CAUSES, EXTENT AND POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY 71 (1986).[5] *See Perreira v. Rediger*, 778 A.2d 429, 434 (N.J. 2001) (noting the influence of the Working Group's recommendation on state enactments.).

For example, New Jersey's statute requires that in all personal injury actions the trial judge shall deduct from the award any portion of the damages that was covered by health insurance. N.J. Stat. Ann. §2A:15-97 (2000). The legislature's intent was "to shift the burden, at least to some extent, from the liability and casualty insurance industry to health and disability third-party payers." *Perreira, supra,* at 436, quoting *Lusby v. Hitchner*, 642 A.2d 1055, 1061 (N.J. Super. 1994).

In such circumstances, a plaintiff's personal injury award contains no double recovery or unjust enrichment. An ERISA plan certainly has no equitable or moral entitlement to funds that the legislature has decided should be credited to the tortfeasor precisely so that the burden would be shouldered by health plans.

This Court should not depart from its close reading of §502(a)(3) in *Knudson* and indulge in an

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[5] *See also*, 2 American Law Inst., REPORTERS' STUDY: ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 182 (1991) (In a thorough examination of the tort system, the ALI states that, for its recommendation to abolish the collateral source rule to make economic sense, "there must be a bar to any subrogation or reimbursement rights exercised by loss insurers against the tort award.").

expansive interpretation that undermines the efforts of the states to regulate and balance the obligations of both liability and health insurance.

Damage caps may also result in less than full compensation in personal injury actions. Most states place a ceiling on noneconomic damages in certain cases.[6] Six states impose caps on economic damages, including past and future medical expenses, in medical malpractice cases.[7] The impact of damage caps falls most heavily on seriously injured individuals. To allow ERISA plans to repay themselves out of already-inadequate tort recoveries unfairly increases the hardship for those who can least afford to subsidize both the liability insurance industry and employee medical plans.

Most states have also enacted legislation to modify the doctrine of joint and several liability, under which each joint tortfeasor is answerable for all the harms caused.[8] Tort reform statutes typically limit liability to the tortfeasor's percentage of fault. Thus a defendant found to be 33% at fault can be required to pay only 33% of the plaintiff's damages. Yet the typical ERISA reimbursement provision, like MAMSI's, asserts a right to 100% repayment up to the amount of the tort recovery.

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[6] *See* http://www.atra.org/issues/index.php?issue=7340

[7] *E.g.*, Va. Code Ann. § 8.01-581.15 (Michie Supp. 2004). *See generally*, Catherine M. Sharkey *Unintended Consequences Of Medical Malpractice Damages Caps*, 80 N.Y.U.L. Rev. 391 (2005).

[8] *See* http://www.atra.org/issues/index.php?issue=7345 (listing 44 states).

Allowing medical plans unfettered authority to recapture paid benefits out of tort recoveries eliminates the ability of employees to protect themselves against the shortcomings of the tort system through first-party coverage at work. This devalues ERISA coverage and undermines Congress's purpose of fostering employer-sponsored benefit coverage.

Moreover, beneficiaries and their families who are left without resources to obtain needed medical care must necessarily look to Medicaid. This surely undermines Congress's intent that Medicaid serve as "the payer of last resort," not as a subsidy for private medical plans. S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312.

C. Reimbursement Does Not Significantly Reduce the Cost of Coverage for Plan Participants.

A second policy argument advanced in favor of enforcing subrogation provisions is that the income received from reimbursement serves to reduce the costs that must be borne by all plan participants. Without the ability to enforce such provisions, the industry contends, the costs paid by all plan participants must necessarily increase. Brief of Amicus Curiae Self-Insurance Institute of America, *supra,* at 8-9; Brief of Amicus Curiae Central States, Southeast and Southwest Area Health and Welfare Fund at 2, *Knudson* (No. 99-1786).

The insurance industry has consistently failed to demonstrate that, in fact, such recoupment lowers premiums or costs to insureds by any significant amount. *See* Edwin W. Patterson, ESSENTIALS OF INSURANCE LAW §33, at 151 (2d ed. 1957) ("Subrogation is a windfall to the insurer. It plays no

part in the rate schedules (or only a minor one)."). As one authority states,

> The prospect of a successful subrogation collection is not a factor in the insurer's rate determination. In fact, the conjectural and remote nature of subrogation militates against its inclusion as a factor for consideration in the setting of premium rates. Thus, when an insurer pays out on an insured risk, any recovery that the insurer is able to obtain through subsequent subrogation is a windfall to the insurer.

Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure,* 41 S.D. L. Rev. 237, 244 (1996). Another commentator states, "Insurers, consistently fail to introduce the factor of such recoveries into rate-determining formulae, but rather apply recoveries to increasing dividends to shareholders." John F. Dobbyn, INSURANCE LAW IN A NUTSHELL 284 (3d ed. 1996).

For this reason, courts have rejected the cost-containment argument for reimbursement, finding that "anticipated recoveries under subrogation rights are generally not reflected in the computation of premium rates." *DeCespedes v. Prudence Mut. Cas. Co.*, 193 So. 2d 224, 227-28 (Fla. Dist. Ct. App. 1967), *aff'd*, 202 So.2d 561 (Fla. 1967). *See also Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 425 (Mo. Ct. App. 1965) (reimbursement of medical payments coverage "does not, in fact, work a perceptible reduction in the premium charged for such coverage."); *Allstate Ins. Co. v. Druke*, 576 P.2d 489, 492 (Ariz. 1978) (similar); *Maxwell v. Allstate Ins. Cos.*, 728 P.2d 812, 815 (Nev. 1986) (similar).

Self-insured ERISA plans operate differently. Where employers pay for health benefits out of

general assets, reimbursements that go back into the general fund could be used to defray current expenditures. However, the impact on the overall costs of ERISA plans would be slight. Only about one-third of ERISA plan participants are in self-funded plans. Brief of Amicus Curiae Self-Insurance Institute of America, *supra*, at 7. Moreover, a majority of self-funded plans purchase stop-loss coverage from insurance companies to cover large claims. Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 Harv. J. on Legis. 233, 249 (1997). Consequently, most large claims for reimbursement, even against beneficiaries of self-funded plans, will be made by commercial insurers. This was the case, for example, in *Knudson*.

Moreover, the savings that might be passed along to plan participants are miniscule. Health Care Recoveries, Inc., the largest provider of reimbursement collection services, "reported [for 2000] subrogation recoveries averaging approximately $4.8 million for each 1 million persons covered by its clients." Brief of Amicus Curiae Self-Insurance Institute of America, *supra*, at 8, n.9. A savings of only $4.80 per covered person – far less after subtracting the costs of recovery and a profit for Health Care Recoveries, Inc. – on plans that cost over $4,000 annually does not justify the harsh treatment of some beneficiaries.[9]

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[9] *See* Kaiser Family Foundation, Employer Health Benefits: 2005 Summary of Findings (Sept. 14, 2005) at 1 (reporting average annual premium per person of $4,024. Available online <http://www.kff.org/insurance/7315/sections/upload/7316.pdf>

More fundamentally, the cost-containment argument is contrary to Congress's intent in enacting ERISA. The principle of insurance, at its simplest, allows many individuals to pay a relatively modest amount so that a few among them will be protected against financial hardship. Allowing reimbursement lawsuits will impose financial hardship on a few so that the many participants might receive a slight savings. This is insurance running in reverse.

III. ANY EQUITABLE REIMBURSEMENT OF AN ERISA PLAN SHOULD BE LIMITED TO THE REMAINDER OF A TORT RECOVERY AFTER THE BENEFICIARY HAS BEEN MADE WHOLE AND SHOULD REQUIRE THE PLAN TO BEAR ITS SHARE OF ATTORNEY FEES AND COSTS.

If this Court determines that ERISA authorizes plan fiduciaries to sue their beneficiaries for reimbursement, Amicus urges the Court to make clear that such equitable relief must be truly equitable.

A. Equitable Reimbursement Should Allow Repayment of An ERISA Plan Only After the Beneficiary Has Been Made Whole.

Equity does not award a party the pound of flesh called for in a contract the party itself drafted. Rather, "subrogation will be applied or not, according to the dictates of equity and good conscience, and to consideration of public policy, resting, as it does, upon the maxim that no one should be enriched by another's loss. George J. Couch, 16 COUCH ON INSURANCE 2d, § 61:19 (1983).

This Court has observed that Congress intended that the courts look to the settled experience of the common law in giving shape to a "federal common law of rights and obligations under ERISA-regulated plans." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989).

Consistent with the dictates of equity and public policy, most state courts that permit reimbursement out of a tort recovery have adopted a rule of equity, the "made-whole" doctrine:

> Out of the recovery from the third party the insured is to be reimbursed first, for the loss not covered by insurance, and the insurer is entitled to any remaining balance, up to a sum sufficient to reimburse the insurer fully.

Robert E. Keeton, BASIC TEXT ON INSURANCE LAW §3.10(c) (1971).

Currently, the overwhelming majority of states that allow reimbursement have adopted the made-whole doctrine. See Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723 (2005) (summarizing the law of 32 states applying the doctrine). Several federal courts have adopted the made-whole doctrine as the default rule. *See, e.g., Cagle v. Bruner*, 112 F.3d 1510, 1521 (11th Cir. 1997) (applying the made whole doctrine where "the plan does not explicitly preclude" it). *See also* David M. Kono, *Unraveling the Lining of ERISA Health Insurer Pockets--A Vote for National Federal Common Law Adoption of the Make Whole Doctrine*, 2000 B.Y.U. L. Rev. 427, 437 (2000).

This Court should make clear that the made whole doctrine applies in any action for

reimbursement, irrespective of the plan's provisions. "Insurance contracts are prime examples of 'contracts of adhesion' . . . Insurers, due to their greater bargaining position, should not be allowed to use this as a wholesale method for controlling applicable law." *American Service Mut. Ins. Co. v. Bottum*, 371 F.2d 6, 12 (8th Cir. 1967).

B. Equitable Reimbursement Requires Deduction for Attorney Fees and Costs Incurred by the Insured.

MAMSI's plan specifically provided that the plan would bear a proportionate share of the costs and attorney fees expended to create the tort recovery. Most plan subrogation provisions, however, do not, and there is "a strong trend" against requiring plans to pay their fair share where the plan is silent. Amber Anstine, *Erisa Qualified Subrogation Liens: Should They Be Reduced To Reflect A Pro Rata Share Of Attorney Fees?* 104 Dick. L. Rev. 359, 361 (2000). *See, e.g., Ryan v. Federal Express Corp.*, 78 F.3d 123, 127 (3d. Cir. 1996) (refusing to subtract a pro rata share of reasonable attorney fees from the plan's subrogation lien), *Walker v. Wal-Mart Stores Inc.*, 159 F.3d 938, 940 (5th Cir. 1998) (refusing to interpret the plan's provisions to provide for attorney fees and expenses).

Chief Judge Posner, speaking for the Seventh Circuit, observed that refusing to require an ERISA plan to bear a fair share of the legal costs of obtaining the tort recovery "would allow the plan to free ride on the efforts of the plan participant's attorney." *Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Wells*, 213 F.3d 398, 402 (7th Cir.), *cert. denied*, 531 U.S. 985 (2000).

This Court should make clear that such unjust enrichment has no place in an action by an ERISA fiduciary for equitable relief.

CONCLUSION

For the above reasons, the decision of the court of appeals below should be reversed.

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